

MARGIN RESERVED FOR BINDING
 N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH				ARIZONA STATE BOARD OF HEALTH 91	
BUREAU OF VITAL STATISTICS				State Index - - No. _____	
1. County <u>Gila</u>		District <u>Globe</u>		County Registrar's No. <u>340</u>	
Town or City <u>Globe</u>		No. _____		Local Registrar's No. _____	
2. FULL NAME <u>William Herbert Goddard</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number)		St. _____ Ward _____	
(a) Residence. No. _____		(Usual place of abode)		St. _____ Ward _____	
Length of residence in city or town where death occurred <u>6</u> yrs. — mos. — ds.		How long in U. S., if of foreign birth? yrs. mos. ds.		(If nonresident, give city or town and State)	
PERSONAL AND STATISTICAL PARTICULARS					
3. SEX <u>Male</u>	4. COLOR or RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED or DIVORCED <u>Married</u> (write the word)			
5a. If married, widowed, or divorced HUSBAND of <u>Angelina Spear Goddard</u>					
6. DATE OF BIRTH (month, day and year) _____					
7. AGE <u>45</u>	Years _____	Months _____	Days _____	IF LESS than 1 day _____ hrs. or _____ min.	
8. OCCUPATION OF DECEASED					
(a) Trade, profession, or particular kind of work <u>Forest Supervisor</u>					
(b) General nature of industry, business, or establishment in which employed (or employer) <u>USA</u>					
(c) Name of employer _____					
9. BIRTHPLACE (city or town) (State or country) <u>New Mexico</u>					
10. NAME OF FATHER <u>W. P. Goddard</u>					
11. BIRTHPLACE OF FATHER (city or town) (State or country) _____					
12. MAIDEN NAME OF MOTHER _____					
13. BIRTHPLACE OF MOTHER (city or town) (State or country) _____					
14. Informant (Address) _____					
15. Filed <u>11/20, 1922</u> <u>B. G. Fox</u> V. S. No. 1 Registrar					
MEDICAL CERTIFICATE OF DEATH					
16. DATE OF DEATH (month, day, and year) <u>Nov. 18, 1922</u>					
17. I HEREBY CERTIFY, That I attended deceased from <u>Aug 20, 1922</u> to <u>Nov 18, 1922</u> that I last saw him alive on <u>Nov 18, 1922</u> and that death occurred, on the date stated above, at <u>3:50 p.m.</u> The CAUSE OF DEATH* was as follows: <u>Perforated duodenal ulcer</u> <u>Pneumonia</u> <u>119</u> (duration) _____ yrs. _____ mos. _____ ds. CONTRIBUTORY <u>Pneumonia</u> (Secondary) (duration) _____ yrs. _____ mos. _____ ds.					
18. Where was disease contracted if not at place of death? _____					
Did an operation precede death? <u>yes</u> Date of <u>Aug 21</u>					
Was there an autopsy? <u>no</u>					
What test confirmed diagnosis? <u>Physical</u>					
(Signed) <u>Dr. J. H. Fox</u> , M. D. 19 (Address) <u>Globe</u>					
* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)					
19. PLACE OF BURIAL, CREMATION OR REMOVAL <u>Globe</u>				DATE OF BURIAL <u>Nov. 21, 1922</u>	
20. UNDERTAKER <u>E. L. Jones & Son</u>				ADDRESS <u>Globe</u>	